

Isolation Device



Plumbing Inspection Section
805 Central Ave, 5th Floor
Cincinnati, OH 45202

Initial Test Report for Isolation Backflow Prevention Devices

OFFICAL USE ONLY:
Device Tag No: _____
Tagged By: _____
Date Tagged: _____

Test Date: _____

Plumbing Permit No: _____

JOB ADDRESS: _____
BUILDING NAME: _____
CITY: _____ STATE: _____
ZIP: _____ PHONE: _____

1st Check

RELIEF

2nd Check

BACKFLOW PREVENTER

SIZE: _____ MANUFACTURED BY: _____ APPROVED STD: _____
MODEL: _____ TYPE: _____ SERIAL NO: _____

LOCATION OF DEVICE: _____
EQUIPMENT CONNECTED: _____

BILLING INFORMATION
NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
CONTACT PERSON: _____ PHONE: _____

I hereby certify that the above backflow prevention device is in proper operation condition on this date.

TESTER (PRINT): _____ TESTER'S COMPANY: _____

TESTER (SIGNATURE): _____ CERT NO: _____ BUS. PHONE NO _____